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MATERNAL AND CHILD HEALTH INTEGRATED PROGRAM

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MCHIP OVERVIEW

Background

The Maternal and Child Health Integrated Program (MCHIP) in Indonesia is a USAID-funded, three year program from January 2010 to December 2012, with a budget level of USD 9.8 million. This program is being implemented by Jhpiego, in collaboration with Save the Children (SC) and John Snow Inc. (JSI). In support of the MOH Road Map to the 2015 MDGs, MCHIP/Indonesia is being implemented in three districts that are classified as "Health Problem Areas": Serang District in Banten Province; Kutai Timur District in East Kalimantan Province; and Bireuen District in Aceh Province. All districts have areas that are considered "remote".

In April 2011, the program work plan was revised to accommodate scaling up of life-saving interventions throughout the 3 target provinces. This quarterly report reflects the addition of a sub-objective aimed at taking interventions to scale at the provincial level.

The overall objective of the program is to catalyze implementation of existing policies that promote key **evidence based life- saving interventions at scale** in remote areas. To achieve the program goals, MCHIP inputs are contributing to four sub-objectives:

1. Effective implementation of MDG Roadmap for scaling up life-saving interventions to achieve MNCH impact at scale within three remote provinces.
2. Improve maternal and newborn care in the community
3. Improve quality of clinical services at all levels of care
4. Improve management of district health system

Sub Objective 1(cross cutting): Effective implementation of MDG Roadmap for scaling up life-saving interventions to achieve MNCH impact at scale within three remote provinces

Results:
- District teams in three remote areas scaling up high impact interventions district-wide
- Provincial teams in three remote areas implementing plans to scale up high impact interventions in other districts, using technical assistance from core districts.

Sub Objective 2: Improve Maternal and Newborn Care Practices at the Community Level

Results:
- Expanded use of life saving approaches (postnatal care, KMC, CCM) by village midwives and kaders
- Increased knowledge, skills and practices of healthy maternal and neonatal behaviors in the home
- Communities mobilized for action and advocacy

Sub Objective 3: Improve Quality of Clinical Services at all Levels of Care

Results:
- Improved competencies of health care providers for pregnancy, childbirth and postnatal care, including AMTSL, PE/E, newborn resuscitation, and KMC
- Improved systems for assuring quality of care, including the use of performance standards and maternal-perinatal audit

Sub Objective 4: Improve Management of the District Health System

Results:
- Increased use of evidence-based planning at all levels of the health system
- Improved use of LAMAT and MPA to monitor district programs and achievements
- Institutionalized support and resources for maternal, neonatal and child health

QUARTER 3 RESULTS

I. Major accomplishments

- Socialization of MCHIP Mini-University to the Provincial Health Office (PHO) and the District Health Office (DHO) was conducted in all three districts through Pre Mini-University meetings.
- *Kelas ibu* approach replicated within and beyond MCHIP target sites. In Bireuen and Kutai Timur, *Kelas Ibu* has been replicated in 12 non-MCHIP Puskesmas. And in Serang the *Kelas Ibu* has been replicated in non-MCHIP posyandu in target MCHIP sub-districts.
- At the national level, MOH has integrated CCM into the national IMCI framework. MOH with support from the multi-agency working group has committed to the development of national guideline for C-IMCI(Community- Integrated Management of Childhood Illness) and scale up of C-IMCI by 2013.
- MCHIP organized series of activities on the 4th Global Handwashing Day at the National and district levels in October 2011.
- All three district hospitals have issued formal decree on KMC highlighting their commitment to, as well as provision of resources and budget allocation for KMC.
- SBM-R results from the facilities were linked to output indicators – in Serang increase in SBM-R results was in line with increase in number of skilled birth attendants; in Bireuen increase in SBM-R results was in line with increase in number of skilled birth attendants as well as birth at the facilities.
- MCHIP is supporting Mercy Corps, a Child Health Survival Grants Program Recipient, to expand SBM-R to the Private Midwifery practices in Jakarta.
- In Serang an increase in the use of MgSO4 as well as 'rooming in' delivery was observed. Pre-eclampsia / eclampsia is the highest cause of maternal death in Indonesia, however the use of MgSO4 in facilities is poor.
- The Bireuen District Hospital and Ganda Pura Puskesmas was recognized as the best performing facilities in - Mother and baby friendly hospital / RS Sayang Ibu dan Bayi (RSSIB) category within Aceh Province for the year 2011. The District hospital was named as one of the ten best performing hospitals in Indonesia in mother and baby friendly hospital in type C hospital (those that include all four specialists- internist, obgyn, paediatrician, & surgeon).
- The Tirtayasa puskesmas, MCHIP target puskesmas was recognized by the District Health office of Serang as the best performing puskesmas in all aspects of Maternal and Newborn health for the year 2011. RSUD Serang was selected as the best Baby and Mother Friendly Hospital in the Banten Province and the second best Family Planning Hospital at the National level.

II. Narrative description

Sub-objective 1: Effective implementation of MDG Roadmap for scaling up life-saving interventions to achieve MNCH impact at scale within three remote provinces.

MCHIP has been working with the three districts to ensure the completion and submission of the District Road Maps to the Provincial Bappeda. The District road map is a tool for the districts to document their progress toward MDGs 2015 especially for MNCH. In order to catalyze province-wide scale up, MCHIP Mini-University will be conducted in all districts. The Mini-University will showcase the collaboration of the Puskesmas, Rumah Sakit, District Health Office, MCHIP Program, and other stakeholders in the implementation of high impact intervention package.

Mini-university Preparation.

MCHIP staff conducted meeting with the PHO and DHO to discuss plans for Mini-University. Meeting in Serang, on December 8 was attended by PHO, DHO and the representatives from MCHIP Puskesmas to discuss and agree upon the venue, date, agenda, facilitators, and resources needed for the meeting. In Kutai Timur, similar meeting, conducted on Dec 15, was attended by MOH, PHO, and DHO from other districts in the province. Several DHOs from the target provinces are interested in requesting technical assistance from MCHIP target districts. In Bireuen, mini-university preparation meetings were conducted in the previous quarter involving other 23 districts in NAD province.

Program Learning

MCHIP Global held a Program learning meeting in Washington DC in November 2011. MCHIP Indonesia participated and shared lessons learnt in community and quality improvement interventions. Global Program learning framework to document and disseminate lessons learnt was shared in this meeting. MCHIP Indonesia adapted the Global Program learning Framework to the Indonesian context (See Annex 3) and identified opportunities for scale up beyond Mini-University that includes actively sharing lessons learnt such as implementation of SBM-R with the Child Survival Health Grants Program recipient Mercy Corps in Indonesia; sharing approaches with other donors; and working closely with new bilateral, EMAS specifically on lessons learned regarding SBM-R, use of LAMAT, and use of Maternal and Perinatal Death Audits. Additionally a pathway for scale-up of evidence based MNCH interventions is being developed for each of the MCHIP intervention. The scale up pathway identifies policy and program components essential for the scale up of the MNCH intervention (See Annex 4 and 5 for examples).

Sub-objective 2: Improve Maternal and Newborn Care Practices in the Community

Mother's classes (Kelas Ibu).

Kelas Ibu is Mother's classes at the village level where pregnant women and mothers are given key messages in maternal and newborn areas including nutrition/ anemia, exclusive breastfeeding, immunization, skilled birth attendant, newborn and maternal danger signs, hand washing, and family planning. To date MCHIP has facilitated the implementation of *kelas Ibu* in 167 villages (62 villages in Bireuen, 40 villages in Kutai Timur, and 65 villages in Serang) across 3 target districts, up from 153 villages in the last quarter. *Kelas Ibu* will be implemented in two additional villages in Kutai Timur next quarter meeting the MCHIP target coverage in all three districts.

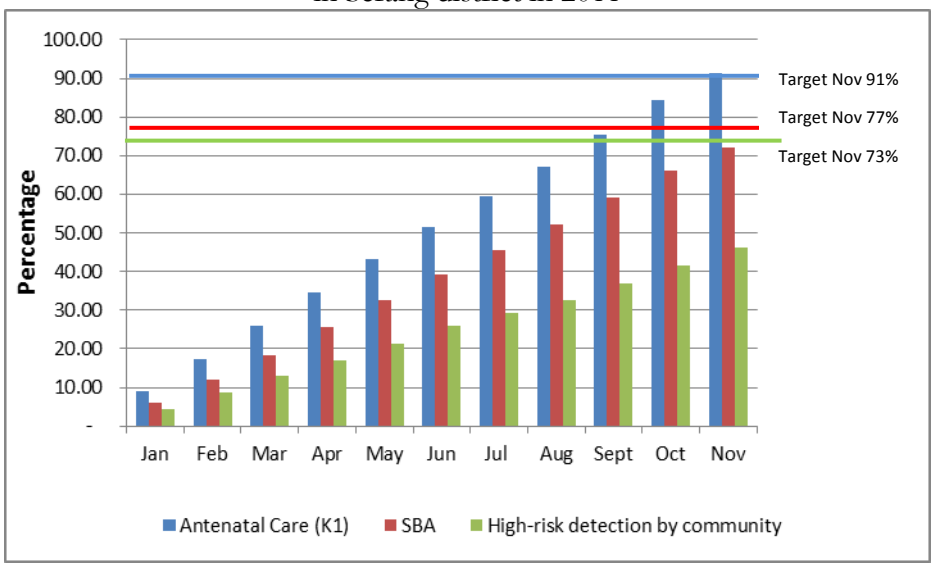
MCHIP initiated and facilitated the update of the MOH flipchart module of *Kelas Ibu* with better illustration and sand self-tests for knowledge assessment for the pregnant women. These flipchart materials will be ready to be printed by MoH in March 2012.

In Bireuen an increasing interest for *kelas ibu* led to replication of the program in 12 non-MCHIP puskesmas. Facilitator training was conducted on November 15-17 to prepare the additional 24 facilitators for 12 Puskesmas in an effort to scale up to other sub-districts. In Kutai Timur, *Kelas Ibu* has also been replicated in 12 non-MCHIP Puskesmas. Facilitator training was conducted on Aug 8-10 for 17 facilitators from 12 Puskesmas. The training was facilitated by 3 district facilitators from Bireuen DHO. In Serang 130 additional *kaders* were trained as *kelas ibu* facilitators to respond to the growing interest from other Posyandu within 65 target villages.

To promote integrated model of handwashing with soap (HWWS), MCHIP also intends to integrate messages on handwashing with soap into all of the *kelas Ibu* topics. In Kutai Timur, MCHIP used the platform of *kelas ibu* to promote HWWS. In the event of the Global Handwashing day, 600 pregnant and post-partum women from 40 villages participated in the event and received handwashing materials including soaps, handkerchieves, buckets, and T-shirts with hand washing logo. In Serang and Bireuen, HWWS was also demostrated and practiced using the 'dancing hands'song in *kelas ibu*.

By providing key messages on MNH, *Kelas ibu* is expected to increase the demand for ANC, skilled birth attendants (SBA), and knowledge of high risk detection. In Serang, cumulative data from local area monitoring (LAMAT) from January to November 2011 showed antenatal care (K1) at 91% (n=estimated number of pregnant women), SBA at 74% (n=estimated number of Pregnant women), and high risk detection by the community coverage at 45% (n=20% of all estimated pregnancies). MCHIP has met and is close to meeting the target for ANC (K1) and SBA set by the Indonesian Minimum Program standards. However, MCHIP is lagging behind on the target of 75% detection of estimated high-risk pregnancy by the community. To address this gap, MCHIP is in the process of developing and rolling out ANC job aids for detection of high risk pregnancy at the community. Similar results were seen in Bireuen and Kutai Timur during January to November 2011 (Annex 6).

Graph 1
Coverage of Antenatal (K1), skilled birth attendant and high-risk detection by community in Serang district in 2011



Midwife-TBA partnerships.

To increase skilled attendance and facility-based births, one of the approaches the government is pursuing is to promote partnerships between midwives and TBAs by clarifying roles, agreeing on mutual financial compensation, and providing recognition of strong partnerships. MCHIP's role in the district is to build capacity of the puskesmas to facilitate the relationship between TBAs and midwives. Some of the factors essential for the successful implementation of this partnership are commitment between midwives and TBAs; support from stakeholders; awareness of the partnership in public; and effective administration of the partnership.

Following the signature of MoU formalizing the midwife- TBA partnership in all three districts, a combined monitoring visit was conducted in all three districts by DHO, participant midwives and TBAs. In Serang monthly meetings between midwives and TBAs will be conducted to discuss challenges in implementation of the partnership. In Kutai Timur, team building activities between midwives and TBAs as well as the socialization of midwife-TBA partnership program was conducted. In Rantau Pulung sub-district, the head of the DHO has urged all deliveries to be sent to the puskesmas and no more home birth. In October 2011, an article on midwife-TBA partnership was posted in Kutai Timur newspaper, *Kaltim Post* (see Annex 7). While in Bireuen, the partnership is covered under local POMA regulation (Obstetric Maternal and Perinatal Program)supported by MCHIP. POMA socialization specific to Midwife-TBA partnership requires pregnant women to conduct the delivery with an SBA to access the Jamkesmas and Jampersal services.

C-IMCI and community KMC (C-KMC)

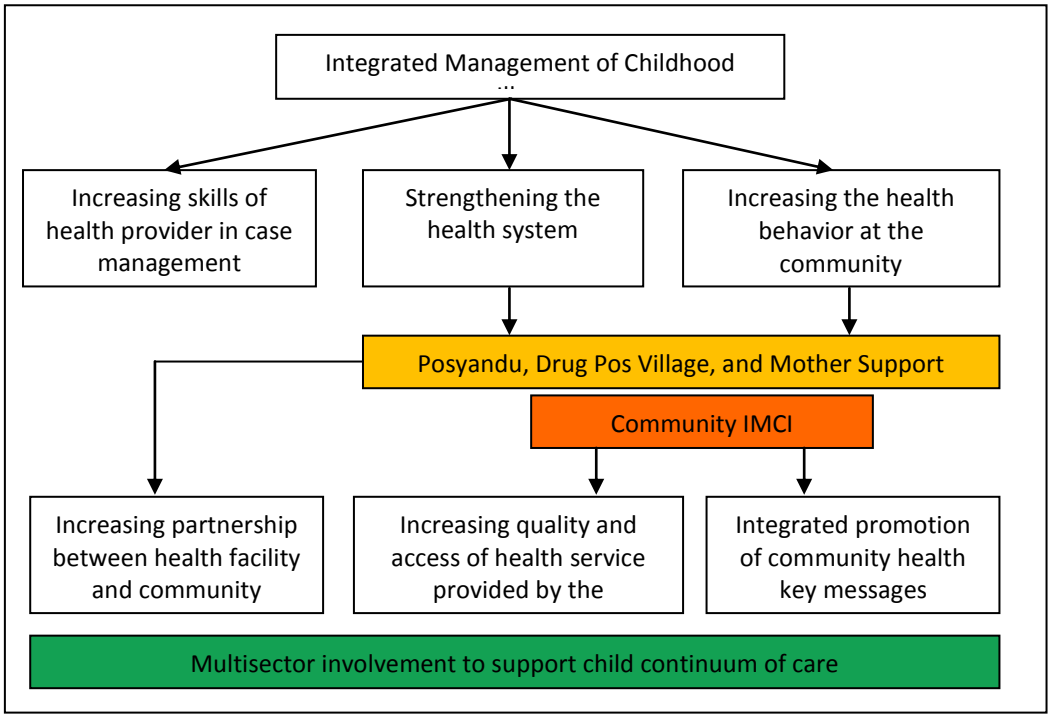
CCM and community C-KMC has progressed during this quarter. Through a series of discussions with MOH, it is agreed that MCHIP would replace the term 'CCM' with C-IMCI to align with the existing IMCI program. Community Integrated Case Management (C-IMCI) is a strategy to deliver life-saving curative interventions for common serious newborn and childhood infections (newborn sepsis, pneumonia, diarrhea and malaria) for children under 5 in communities with limited access to facility-based care. Kangaroo Mother Care (KMC) in

Indonesia is primarily a facility based intervention to manage Low Birth Weight babies. MCHIP in Indonesia is piloting C-IMCI for newborn sepsis, pneumonia, and diarrhea. and KMC. Indonesia currently does not have a national policy on C-IMCI; findings from the C-IMCI pilot will inform the national level policy. The C-IMCI newborn package was updated with the C-IMCI for under five for diarrhea, pneumonia, and malaria at the MCHIP target sites and providers were trained accordingly.

National Level

At the national level, MOH has integrated C-IMCI into the IMCI framework (See Figure 2) thus expanding IMCI from the facility to the community. During this quarter, series of MAWG (multi agency working group) meetings were conducted. The MAWG meeting was attended by the MOH, NGOs, and other stakeholders to develop national guideline for C-IMCI. MCHIP shared lessons learnt on C-IMCI implementation from Bireuen and Kutai Timur. UNICEF shared lesson learned from their program in Jaya Wijaya and Brebes.

Figure 2
IMCI Framework



Action Plan from the MAWG meeting is listed below. MOH will lead these activities with support from the MAWG.

1) Develop national C-IMCI guideline (where C-IMCI will be a part of IMCI framework).
2) Develop laws for protection of *kaders* to perform CCM by March 2012.
3) Disseminate/Pre-test national guideline by May 2012.
4) Finalize national guideline by October 2012.
5) Prepare for scale up in 2013 by:
    - Conducting needs assessment for target area of intervention (low access)
    - Identifying funds

- Preparing national facilitator
- Planning for logistic support

6) Scale-up/Expand to other district in Indonesia by 2013.

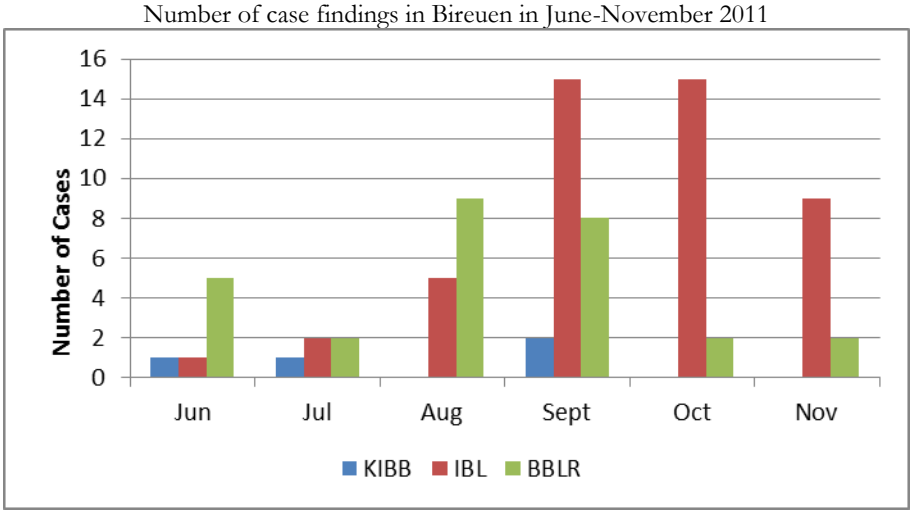
District Level

The implementation of C-IMCI for newborn was countinued during this quarter. In Bireuen, midwives are trained to provide C-IMCI/C-KMC. In Kutai Timur given the shortage of midwives, *Kaders* are trained to provide C-IMCI /C-KMC when midwives are not available. The C-IMCI/C-KMC providers are supervised by the midwife coordinator or Puskesmas doctor.

In Kutai Timur, a new C-IMCI specialist was identified in September 2011 to drive the C-IMCI implementation. In collaboration with DHO, MCHIP conducted a series of trainings for C-IMCI - 35 kaders and health workers in 5 Puskesmas; facilitator training for 17 personnel, health workers and kader training for 43 personnel.Competency assessment was also conducted for 16 health workers and 19 kaders. C-IMCI tools and kits were distributed to the providers post -training.

In Bireuen, following the series of trainings in the last quarter, a supervision and monitoring visit at the Puskesmas was conducted in coordination with the DHO. The purpose of the monitoring visit was to identify and resolve challenges in C-IMCI implementation and strengthen the recording and reporting system of C-IMCI case findings. In this quarter 68 cases were identified including those for suspect for severe newborn infection (KIBB), Local bacterial Infection (IBL), and Low birth weight babies (BBLR). Number of cases identified in Bireuen is shown in Graph 2 (below).

Graph 2
Number of case findings in Bireuen in June-November 2011



A refreshing training was also conducted in Bireuen for health workers and supervisors in each Puskesmas. The training was led by sub-district facilitators to update the C-IMCI workers on new information and revision regarding C-IMCI module content. To date, there are 15 facilitators in Kutai Timur and 21 facilitators in Bireuen. Besides the CCM package for newborn, the implementation of C-IMCI for underfive package was started in Bireuen with refresher training of the facilitators and supervisors in October for 21 participants. A total of

36 facilitators to date are available in MCHIP Puskesmas to support the implementation of C-IMCI and community KMC in both districts

Table 1
Number of facilitators in Bireuen and Kutai Timur

Bireuen	Kutai Timur
• Peudada (3 person) • Jeumpa (3 person) • Juli (3 person) • Peusangan Selatan (4 person) • Makmur (8 person) • Gandapura (11 person)	• Dinas Kesehatan (3 person) • Teluk Pandan (2 person) • Rantau Pulung (2 person) • Bengalon (2 person) • Kaliorang (2 person) • Kaubun (2 person) • Sangkulirang (2 person)

To support the community KMC, MCHIP also conducted a meeting in Bireuen on December 30—31 for 717 kaders and 7 TBAs. The purpose of the meeting was to build their competencies to support families to care for LBW newborns using KMC.

Handwashing for newborn survival.

MCHIP, in collaboration with the Global Alliance for Handwashing, conducted series of events on the 4th Handwashing Day at the National level. The event on October 14 was also attended by National Coordination Committee (Rakornas) STBM (*Sanitasi Total Berbasis Masyaraka*). MCHIP had HWWS exhibition booth at the event. The national event was launched by Ministry of Health, Endang Rahayu Sedyaningsih, and Ministry of General Affair, Djoko Kirmanto,and attended by 3.100 primary school students from Primary Schools in DKI Jakarta to promote the importance of handwashing as an integrated model to improve neonatal and maternal health.

MCHIP also celebrated the 4thHWWS Day in 3 districts. In Bireuen, the event organized on October 14-15 was attended by 3,793 participants.At the puskesmas level 176 participants attended the HWWS campaign. Village midwives and *Kaders* conducted home visit for 209 pregnant and postpartum mothers in 62 villages to promote and practice HWWS. HWWS promotion in Posyandu was attended by 3,100 mothers in 6 sub-districts, and Handwashing Day event in district level was attended by 300 participants from local government, DHO, Puskesmas and community. Radio talk show on HWWS conducted by MCHIP reached 5, 000 audiences. The show featured 3 resource people from DHO, MCHIP and Mother's class participants discussing HWWS isuues and presenting jingle quiz.

In Serang, the event was celebrated on October 14 in 4 Puskesmas. HWWS campaign in each Puskesmas was attended by local governenment, DHO, kader, village midwives, TBAs and

community members. The Head of DHO called out HWWS campaign to be conducted simultaneously in all Puskesmas on October 15. The HWWS campaign was also integrated with *kelas ibu* in some Posyandu and midwives-TBA partnership in Padarincang Puskesmas.

In Kutai Timur, HWWS day event was conducted on October 18 in 6 Puskesmas and 1 hospital to promote the importance of HWWS in preventing newborn deaths from infectious causes. This event was attended by 340 participants from the DHO, hospital, and community members. Besides the campaign in each Puskesmas, radio talkshow was also held in GWP Radio to socialize the importance of HWWS to audiences in its subdistrict coverage areas of Sangatta Utara, Sangatta Selatan, Teluk Pandan, Rantau Pulung and Bengalon. Newspaper is one of media for socialization and promotion for HWWS program. Some articles on HWWS program were posted in Kutai Timur newspaper, *Kaltim Post* (see Annex 7).

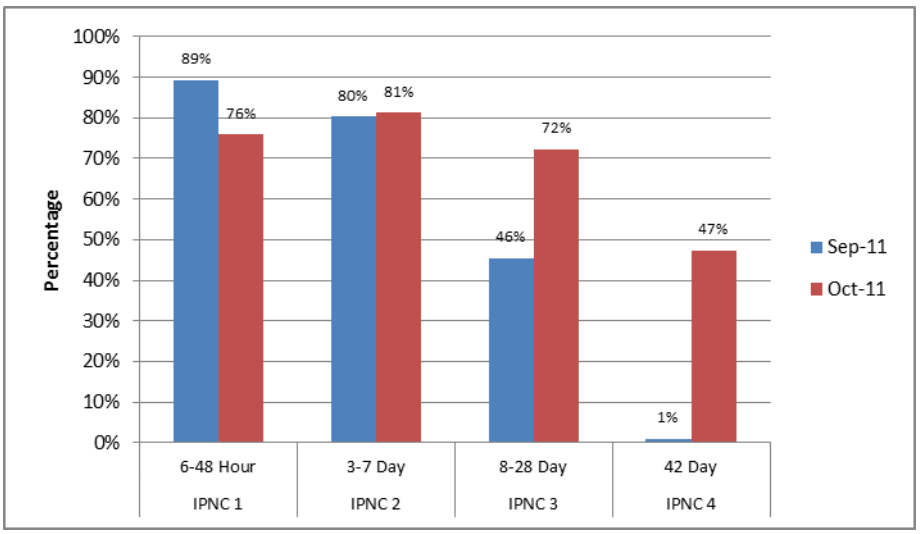
Sub-objective 3: Improve quality of clinical services at all levels of care

Integrated Postnatalcare

MCHIP in Indonesia is developing an integrated model for Post natal care (PNC) to be scaled up at the national level. The current PNC schedule for skilled care differs for the mother and the newborn, and few postnatal visits are happening at all. The period during which mothers and newborns are most at risk, 24 to 48 hours after birth, is often missed, as this early visit is not integrated into community health services.The three MCHIP target districts have agreed to allow midwives to conduct integrated PNC visits for mothers and newborns. The guideline for the four recommended integrated postpartum visits are 6-48 hours, 3-7 days, 8-28 days, and 36-42 days. After the socialization of IPNC in the previous quarter, MCHIP is supporting village midwives to conduct home visit and use the IPNC forms for recording and reporting. In Serang, 65 village midwives conducted home visit for neonatal and postpartum mother (KN and KF) during December 2011.Jobs aids are being developed for midwife to provide sufficient information to perform integrated postnatal care for both mother and child in collaboration with the MoH.

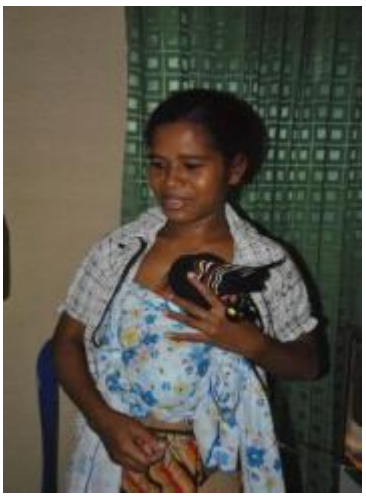
Accurate recording and reporting of IPNC data is a challenge. The LAMAT has provisions to record postpartum and neonatal visits as separate visits only. MCHIP is currently collecting data on IPNC using a separate IPNC form. In Serang, IPNC data collection started in September 2011(See Graph 3). In the Pandarincang sub-district of Serang, of the estimated 112 live births in September 89% received IPNC 1 and the coverage for the subsequent visits decreased. In October for the same site, of the 112 estimated live births, 76% received IPNC 1 and the coverage for subsequent visits decreased. MCHIP will review the data through December to understand the reason behind the disparity and the declining trend and develop a plan to address identified gap. LAMAT data for the same site showed that of the 144 postpartum visits (only third postpartum visits are recorded in LAMAT) in October 2011, 43% was IPNC. For November of the 118 postpartum visits, 56% were IPNC visits.

Graph 3
Number of IPNC coverage in Serang in September-October 2011



Kangoroo Mother Care (KMC)

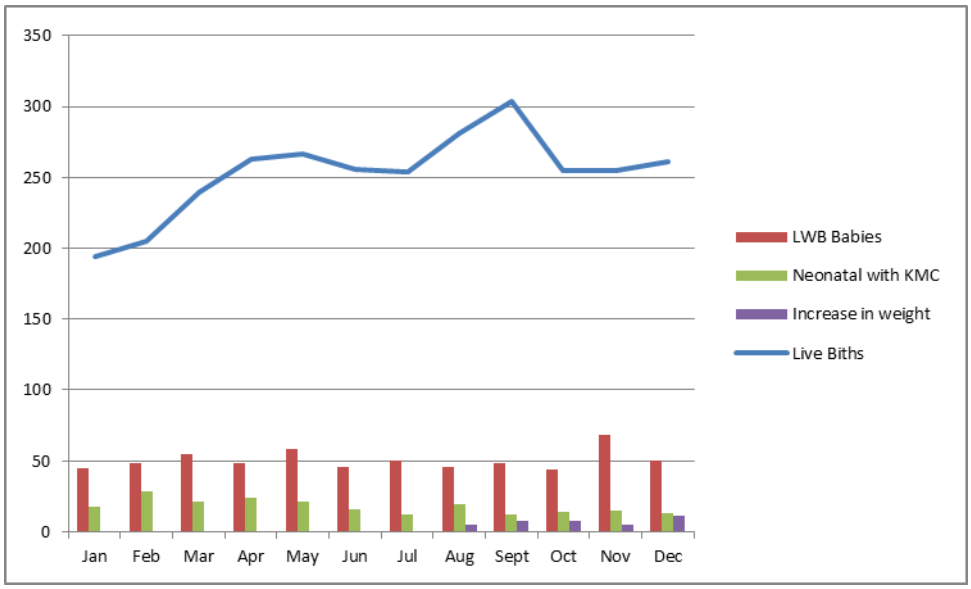
MCHIP is expanding facility based KMC in three MCHIP target hospitals in the three districts. *Perinasia* (Indonesian Perinatologist Association) that had been leading the effort of establishing facility based KMC is providing technical assistance to MCHIP for KMC expansion.



The initial KMC training has been provided to all three district hospitals. *Perinasia* is now conducting regular assessment, monitoring, and supervision visits. In Bireuen, the second monitoring and evaluation visit was conducted from October 25-26. RS Fauziah has initiated KMC services, KMC room is available with 4 beds. MCHIP also provided the IEC materials for KMC implementation to the hospital.

RSUD Serang has also started services on KMC. The second monitoring and evaluation visit was conducted from October 27-28. Data from RSUD Serang shows 20% (n=3,034) LBW babies, 35% of whom (n= 606) received KMC from January through December 2011. Amongst the babies who received KMC increase in weight was recorded starting in August. Graph 4 below shows the trend on live births, LBW babies, KMC received, and increase in weight for newborns that received KMC. Currently the RSUD in Serang is building a new facility for Mothers and newborns with space for mothers to practice KMC. The building will be ready in April which may lead to an increase in the KMC cases.

Graph 4
Number of LBW Babies with KMC in RSUD Serang in January—December 2011



KMC service was also started in RSUD Sangatta in Kutai Timur. The second monitoring and evaluation visit was conducted in December. RSUD Sangatta is committed to establishing itself as the center of excellence for KMC for other hospitals and Puskesmas within Kalimantan Timur area. KMC room is available with 4 beds, job aids have been printed and distributed to promote the KMC, and pediatrician and staffs have the suffient capacity to provide KMC services.

One of the challenges identified in all sites was the separation of mothers and newborns after birth. While newborns often stay in hospitals for a few days, mothers often leave early. To address this challenge, MCHIP has suggested to the RSUDs to provide a separate rented space for the mothers to stay and provide KMC for additional 2-3 days without any additional charges to the family

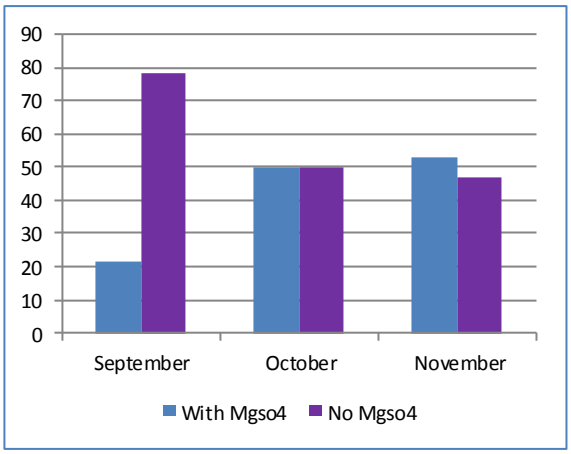
Despite the challenges, all three target hospitals already have a standard operational procedural challenge, and formalized decree to ensure their commitment in improving KMC services by allocating resources including budgetary provisions for regular implementation and monitoring of KMC.

Clinical Mentoring and Training.

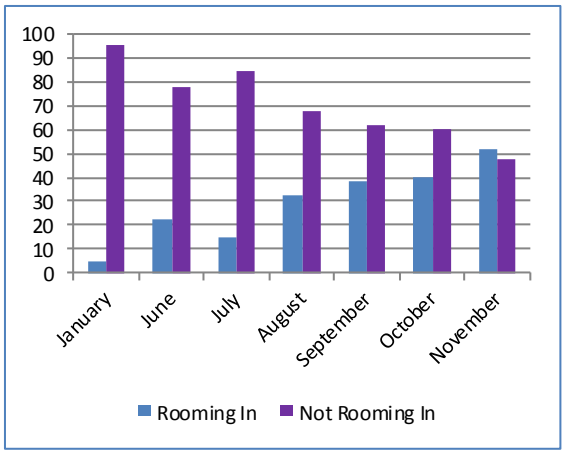
During this quarter, MCHIP continued providing on-the-job mentoring at all 17 puskesmas and 3 hospitals. Basic supplies and equipment were provided for infection prevention, and minor renovations were completed at the puskesmas. Intervention to date in 3 districts include standards to improve and monitor quality, onsite training on infection prevention, onsite training on KMC, ER, AMTSL, IPNC, MgSO4 for staff, and, clinical on the job mentoring.

MCHIP has hosted several midwife volunteers in the past year to support adoption of evidence based clinical practices at the facilities and the puskesmas.In Serang, a midwife volunteer, Kathy Jeffers,was providing clinical mentoring to RSUD Serang and 5 Puskesmas with a focus on reinforcing use of infusion pumps, and MgSO4. Kathy also promoted and facilitated the adoption of KMC, infection prevention, neonatal resuscitation, labor support, early breastfeeding and documentation (partograph) practices. An increase in MgSO4 utility and "rooming-in" in Puskesmas during this quarter was observed in Serang (graph 5and6). "Rooming in" practice refers to keeping the mother and the newborn together after birth, which is not commonly practiced in Indonesia.

Graph 5
MgSO4 utility in Puskesmas in Serang, 2011



Graph 6
Rooming-in Delivery in Puskesmas in Serang, 2011



Budi Kemuliaan Hospital, a private hospital in Jakarta, known for their excellent MNH services, mentored the MCHIP target hospitals to strengthen the management of emergency obstetrics and neonatal cases. In the previous quarter, key providers and management staff from the MCHIP district hospitals visited Budi Kemuliaan hospital to attend a workshop and direct observation on improving management of emergency cases. In this quarter, consultants from the Budi Kemuliaan hospital conducted an assessment visit of the MCHIP sites to observe and support the implementation of follow up items identified by the providers and the management staff in the previous quarter. The Budi Kemuliaan team also visited the district officials to advocate for allocation of resources for emergency maternal and newborn care at the district hospital. A refresher training on BEONC in collaboration with the P2KS was also conducted in the Serang hospital as a follow on for 14 GPs from 5 Puskesmas on November 23-25 in this quarter. The training was continued in December for 10 GPs with a focus on management of hemorrhage , PE/E including MgSo4 use, neonatal resuscitation, hypovolemic shock as well as ultrasonography update.

Improved systems for quality assurance.

Standards-Based Management and Recognition (SBM-R) is a practical approach to improving the quality of health care and the performance of service delivery systems. With technical assistance from Jhpiego, the approach has been implemented in over 20 programs in developing countries and across several health areas, including maternal child health, reproductive health, HIV/AIDS, and malaria Under MCHIP program, SBM-R has been implemented in three districts in the three Indonesia; Bireuen, Serang and Kutai Timur.

Target hospitals, facilities, midwives in all three districts continued to monitor and recognize their progress using the SBM-R performance standards. At each level the assessments are conducted using the checklist that covers performance standard indicators for areas shown in Table 1 below. The standards focus on proven high impact interventions such as the AMTSL, use of Magnesium sulphate for management of PE/E, iron supplementation for prevention of maternal anemia, emergency obstetrics and newborn care, newborn resuscitation for management of newborn asphyxia, and essential newborn care.

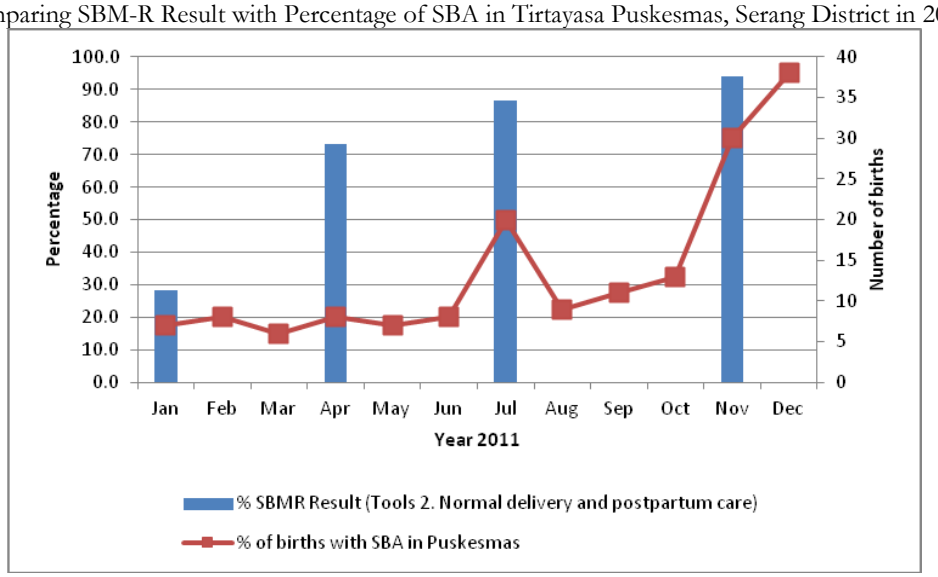
Table 2
SBM-R Performance Standard at All Levels

Midwife Level	Puskesmas Level	Hospital Level
Tool 1. Pregnant women care Tool 2. Normal delivery and newborn care Tool 3. Mother and newborn postpartum care Tool 4. Delivery complication Tool 5. Contraceptive methods Tool 6. Family Planning – Oral contraceptive and injection Tool 7. Child immunization Tool 8. Under five children care Tool Infection Prevention	Tool 1. Physical Facility Tool 2. Antenatal Care Tool 3. Pregnancy Complication Tool 4. Normal delivery and postpartum care Tool 5. Management of delivery complication Tool 6. Postnatal complication Tool 7. Postpartum care Tool 8. IMCI for newborn<2 months Tool 9. IMCI for 2 month to 5 years child Tool 10. Child Immunization Tool 11. Contraceptive methods Tool 12. Infection Prevention	Tool 1. Infection Prevention Tool 2. Pregnancy Complication Tool 3. Normal delivery, delivery, postpartum and newborn care Tool 4. Delivery complication Tool 5. Antenatal and postpartum care Tool 6. Family planning service in hospital

During this quarter, facilities and midwives in all three districts continued to monitor and recognize their progress using the SBM-R performance standards. In general, the 3 districts have conducted the 3rd or 4th cycles of SBM-R monitoring data collection.

In Serang, the increase in the SBM-R scores was observed in line with the increase in number of births with skilled birth attendants at the facility (graph 7). We are not able to attribute the increase in facility based births directly to SBM-R, there may be other factors such as the *Jampersal* that may have led to the increase. In the next quarter we will work toward analyzing this data further and collecting qualitative testimony to support our results.

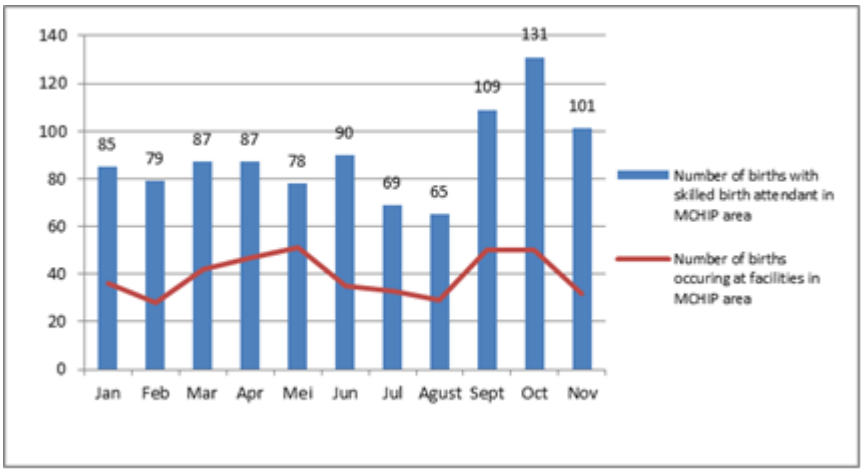
Graph 7
Comparing SBM-R Result with Percentage of SBA in Tirtayasa Puskesmas, Serang District in 2011



As reported in the LAMAT data from the three districts, Puskesmas in all districts observed an increase in the number of births with skilled birth attendants. The management of births occurring at facilities varied- Serang showed an increasing trend, Kutai Timur and Bireuen showed a fluctuating trend. For Bireuen this could possibly be due to clients accessing childbirth services at private facilities that are readily available in the area (see Annex 8). The graph 8 (below) shows an increase in the number of skilled birth attendants and births occuring at facility in Kutai Timur.

Graph 8

Number of Monthly SBA and Birth at Facility in Kutai Timur District in January—November 2011



As a result of MCHIP's emphasis on increasing births at the facility, hospital and Puskesmas in MCHIP district were selected as the best facilities among province or at the national level. Bireuen Hospital and Gandapura Puskesmas were selected as the best hospital and Puskesmas among all hospitals in Aceh province in the Baby and Mother Friendly Hospital Competition 2011. The competition was conducted by Province Health Office. This achievements was also announced and posted in Aceh newspaper, *Serambi Indonesia,* in October 2011 (see Annex 7). The Bireuen hospital was subsequently selected as one of the top ten hospitals in the category of the baby and mother friendly hospital in the nation. As well as RSUD Serang was selected as the best Baby and Mother Friendly Hospital in Banten Province and also the second best of Family Planning Hospital at National level. Puskesmas Tirtayasa, one MCHIP focus Puskesmas in Serang district, was also selected as the best Puskesmas in 2011 amongs Puskesmas in Serang district.


Bireuen Juara Lomba
RS Sayang Ibu

Sub-objective 4: Improve Management of the District Health System

Evidence-based Local Planning.

Approaching the next cycle of *Musrenbang* local planning, MCHIP supported the pra-Musrenbangdes workshop for 5 sub-districts in Serang on December 2011. The pra-musrenbangdes aimed to generate draft plans and budgets from 65 villages in preparation for Musrenbangdes activity in January 2012.

In Kutai Timur, refresher training for pra-musrenbangdes facilitator was conducted prior to pra-musrenbangdes workshop. The training was conducted for 8 facilitators from 6 Puskesmas on December 2011. MCHIP support the pra-Musrenbangdes workshop for 6 sub-districts in Kutai Timur on December 2011.

Improved process for conducting maternal-perinatal audits.

Effective maternal and perinatal audits are associated with improved quality of care and reduction of severe adverse outcomes[1]. Maternal Perinatal Audit (MPA) is for tracking the causes of maternal and perinatal morbidity and mortality to prevent future cases. MPA helps health personnel determine the conditions that resulted in the mortality/morbidity of mothers and newborns. The MPA can also function as a tool for monitoring and evaluation of the referral system. It is national policy of Indonesia to conduct a verbal autopsy of every maternal and perinatal death. The MPAs are done through a collaborative team from the DHO and the district hospital. Additionally the MOH has recently developed a revised process for conducting MPA and all districts are expected to implement this process. However, in many districts, the process is only partially implemented, if at all. The revisions pertain to the "no name, no blame, and no shame" policy, the audits are conducted in a confidential and blame free environment. MCHIP is providing inputs to establish routine maternal and perinatal audits in the three districts as one of the pilot project for the revised new guideline for implementation.

Continuing the MPA workshops at the national level conducted in the last quarter, follow up action to improve district processes for conducting MPA was completed at the district level. During October 2011 in Bireuen, MPA socialization was conducted at the hospital. Both in Bireuen and Serang, review meetings of deaths were condcuted to address the causes, both medical and non- medical aspects as well as seek solutions to prevent reccurence of similar cases in the future.

In Kutai Timur, MPA Training was conducted in November in two batches (November 3-4 and 10-11) for 4 Puskesmas. As a follow on to the training midwives will conduct a verbal autopsy using the revised MPA form and prepare to establish the MPA team at district level. In Kutai Timur, 6 verbal autopsies out of 7 maternal and neonatal deaths were conducted, while in Serang 14 verbal autpsy out of 14 deaths was conducted.

[1]Pattinson RC, Say L, Makin JD, Bastos MH: Critical incident audit and feedback to improve perinatal and maternal mortality and morbidity. *Cochrane Database Syst Rev* 2005, (4):CD002961.

Data management.

In order to strengthen data collection, reporting, and management, MCHIP M&E staff and provincial/district trainers continue to train and follow up on PWS/LAMAT in 3 districts during this quarter. Participants in the training included the head of the puskesmas, midwife coordinator, data operator, MCH manager, village midwives, and DHO representatives. MCHIP continued to assist Puskesmas by strengthening the monthly meeting (mini lokakarya) at Puskesmas level to work with village midwives and coordinator midwives to ensure data quality in MCH recording and reporting. Besides the mini lokakarya, the M&E officer or other MCHIP technical staff joined the midwives strengthening meeting on a monthly basis.The meeting was attended by village midwives and midwives coordinator to discuss in detail the MCH Program including MCH-LAMAT data, MPA, SBM-R, KMC, PONED implementation and others. DHO and MCHIP assits midwife coordinator and village midwives to use the updated form and report.

Institutionalized commitment for MNCH.

In order to institutionalize commitment for MNCH in Bireuen, several Local Laws on MNCH was drafted and finalized in the last quarter. At the district level Qanun KIBBLA, and POMA regulation (Obstetric Maternal and Perinatal Program) was finalized. POMA regulation pertains to a memorandum of understanding (MoU) between client seeking childbirth services and the provider. The MoU outlines the evidence based continuum of care

services for mothers and newborns to be given by the provider and accessed by the client. The MoU intends to increase the skilled birth attendants in Bireuen by providing Jampersal and Jamkesmas services to clients only after signing the MoU. As a follow on from the last quarter, Bireuen conducted POMA socialization at district and sub-district level. Series of meetings in Puskesmas and villages were conducted for the socialization of the POMA, attended by Puskesmas staff and multistakeholders. All village leaders are committed to supporting the POMA services within their village and diseminate POMA decree to their community, particulary to midwife and pregnant women. A radio talk show also held in BITA FM Radio Bireuen with key speakers consist of Bupati, Head of DHO, community leader, DTPS team and MCHIP. There are approximately 5,000 listeners within Bireuen district.

For the Qanun KIBBLA, Bireuen conducted public hearing on the MNCH Local Regulation on October 27 to get input from multi stakeholders and consultation with Law Bureau on November 10. In Kutai Timur, local government has completed a draft of the Qanun KIBBLA draft and it is in the process of signatory approval.

At the village level, *Perdes* (Peraturan Desa – Village regulation) for MNCH program institutionalizes commitment. In Bireuen, a coordination meeting with local government and stakeholders was conducted on November 2011 to move the *perdes*. A draft of the *Perdes* for Gandapura and Makmur villages was developed. Draft of *Perdes* for 12 villages in Kutai Timur

is in the process of development. To date, 33 *Perdes* have been developed and approved in Serang, more than the targeted 10.

MCHIP is also working toward revitalization of the MNCH teams in the districts and the sub-districts. The goal of the MNCH team is to advocate for and monitor the districts and sub-districts in their progress toward meeting the MDGs. In Serang, the MNCH team in sub-district and district level was established under HSP technical assistance in 2009. A quarterly review meeting of MNCH teams at district and sub-district level was conducted in Novemberand December 2011. During this meeting MNCH team activity was discussed and an action plan for January to March 2012 period was developed. MNCH team meetings at the 5 sub-districts was conducted from November 9—10 and attended by 89 participants in total. MNCH team meeting at district level was conducted on December 15, and attended by 36 participants. While in Kutai Timur and Bireuen, the process for the revitalization will be initiated in the next quarter.

Management

Ibu Wita Sari replaced Anne Hyre as the Chief of Party for MCHIP in October. Technical leader for Governance was recruited interanlly to replace Ibu Wita. New District Team Manager was recruited for Bireuen, as the previous District team manager transitioned to EMAS. New position for the CCM specialist in Kutai Timur was recruited and oriented in this quarter. MCHIP is currently recruiting for a new technical leader for community based in Jakarta.

Annex 1
Progress Toward MCHIP Indicator (up to September 2011)

Indicator	Bireuen			Kutai Timur			Serang		
	LOP Target	**Achievement**	*Notes*	**LOP Target**	**Achievement**	*Notes*	**LOP Target**	**Achievement**	*Notes*
Number of district in MCHIP Province scaling up interventions	**9**	**1**	Target is 40% of the number of districts in the province.	**5**	**1**	Target is 40% of the number of districts in the province.	**3**	**1**	Target is 40% of the number of districts in the province.
Number of sub districts in MCHIP district scaling up interventions	8 (6 MCHIP, 2 non-MCHIP)	18 (6 MCHIP,12 non-MCHIP)	Replication for IPNC, Kelas Ibu and LAMAT Data in non-MCHIP sub-district	8 (6 MCHIP, 2 non-MCHIP)	17 (6 MCHIP, 11 non-MCHIP)	Replication for Kelas Ibu in non-MCHIP sub-district	7 (5 MCHIP, 2 non-MCHIP)	**5**	Replication within the 5 MCHIP target sites only.,
Percentage increase in number of births occurring at facilities (difference in the number of births between the first and the last six months/number of births in the first six months)	**10%**	**68%**	80 births in Jan-Jun 2011 and 134 births in Jul-Dec 2011 in 6 target Puskesmas (	**10%**	**15%**	203 births in Jan-Jun 2011 and 239 births in Jul-Dec 2011 in 6 target Puskesmas	**10%**	**108%**	189 births in Jan-Jun 2011and 393 births in Jul-Dec 2011 in 5 target Puskesmas
Percentage of village midwives in MCHIP supported areas are competent in AMTSL *	**100%**	**40%**	Baseline data from AMTSL survey	**100%**	**5%**	Baseline data from AMTSL survey	**100%**	**52%**	Baseline data from AMTSL survey
percentage of women with vaginal births who received Active management of the third stage of labor (AMTSL) at USG-supported facilities	**100%**	39%	95 out of 246 in Peusangan Selatan Puskesmas	**100%**	13%	109 AMTSL out of 851 live birth in Bengalon, Sangkulirang, Kaliorang, Kaubun	**100%**	85%	1924 AMTSL out of 2255 live birth in Pamarayan and Petir

Indicator	Bireuen			Kutai Timur			Serang		
	LOP Target	**Achievement**	*Notes*	**LOP Target**	**Achievement**	*Notes*	**LOP Target**	**Achievement**	*Notes*
Percentage of MCHIP health facility using MgSO4	**100%**	**14%**	1 out of 6 target facilities (District Hospital Dr. Fauziah)	**100%**	**71%**	Puskesmas Kaliorang, Rantau Pulung, Sangkulirang, Rantau Pulung and Kaubun	**100%**	**83%**	Puskesmas: Kramat Watu, Padarincang, Pamarayan, Tirtayasa, Petir
Number of MCHIP puskesmas PONED treating complications	**6**	**3**	Puskesmas: Jeumpa, Gandapura, Peudada	**6**	**6**	Puskesmas: Sangkulirang, Kaubun, Kaliorang, Sepaso, Rantau Pulung, Teluk Pandan	**5**	**5**	Puskesmas: Kramat Watu, Padarincang, Pamarayan, Tirtayasa, Petir
Percentage of maternal or neonatal deaths with autopsy verbal conducted	**100%**	**100%**	18 deaths with 18 autopsy verbal in 2 Puskesmas (Peudada, Makmur)	**100%**	**100%**	7 deaths with 7 autopsy verbal in 3 Puskesmas (Bengalon, Teluk Pandan, Sangkulirang)	**100%**	**100%**	24 deaths with 24 autpsy verbal in 5 Puskesmas (Kramat Watu, Padarincang, Pamarayan, Tirtayasa)

* Please note that oxytocin is used universally in Indonesia.

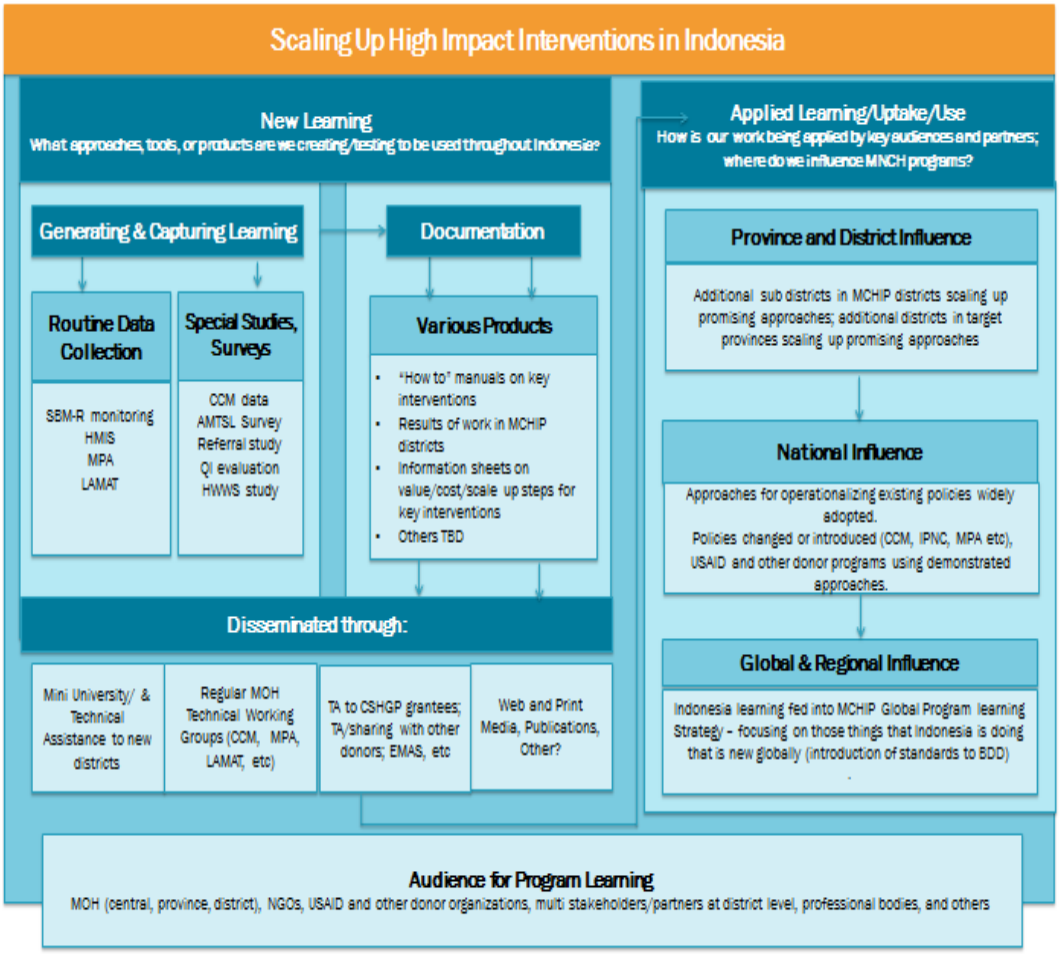
Annex 2
Training Database as Per December 2011

No	Training	Bireun			Kutai Timur			Serang			All Districts		
		Total	M	F	Total	M	F	Total	M	F	Total	M	F
SO 2: Improved Maternal and Newborn Care Services and Practices at the Community Level													
2.1	Kader Training for MSG	44	0	44	23	7	16	0	0	0	67	7	60
2.2	Kader Training for CHC/Desa Siaga	0	0	0	48	25	23	201	5	196	249	30	219
2.3	KMC Socialization for Cadre	29	0	29	0	0	0	0	0	0	29	0	29
2.4	TOT CCM Facilitator	15	0	15	18	2	16	0	0	0	33	2	31
2.5	MSG Facilitator Training District Level	7	0	7	23	2	21	7	1	6	37	3	34
2.6	MSG Facilitator Training Puskesmas Level	14	1	13	17	5	12	15	2	13	46	8	38
2.7	MSG Facilitator Training Village Level	146	0	146	140	12	128	197	2	195	483	14	469
2.8	MSG Facilitator Refresh Training	167	0	167	106	2	104	0	0	0	273	2	271
2.9	CCM Training for Health Worker	69	0	69	79	6	60	0	0	0	148	6	129
2.10	CCM Training for Kader	0	0	0	18	3	15	0	0	0	18	3	15
2.11	CCM Supervisor Training	44	6	38	15	3	12	0	0	0	59	9	50
2.12	TOT CCM Training for U5 Package	0	0	0	50	4	46	0	0	0	50	4	46
2.13	Cadre Training of Desa Siaga Funding	0	0	0	134	49	85	0	0	0	134	49	85
2.14	Kader Training for Ambulance Desa Siaga	0	0	0	121	78	43	0	0	0	121	78	43
2.15	C-KMC Training for Village Midwives	131	0	131	0	0	0	0	0	0	131	0	131
2.16	P4K Training Refreshing	0	0	0	0	0	0	193	30	163	193	30	163
	TOTAL	**666**	**7**	**659**	**792**	**198**	**581**	**613**	**40**	**573**	**2071**	**245**	**1813**
SO 3: Improved Quality of Clinical Services at all Levels of Care													
3.1	SBMR Workshop	0	0	0	0	0	0	50	8	42	50	8	42
3.2	Refreshing Training Midwives	66	0	66	0	0	0	0	0	0	66	0	66
3.3	APN Training	36	0	36	1	0	1	0	0	0	37	0	37

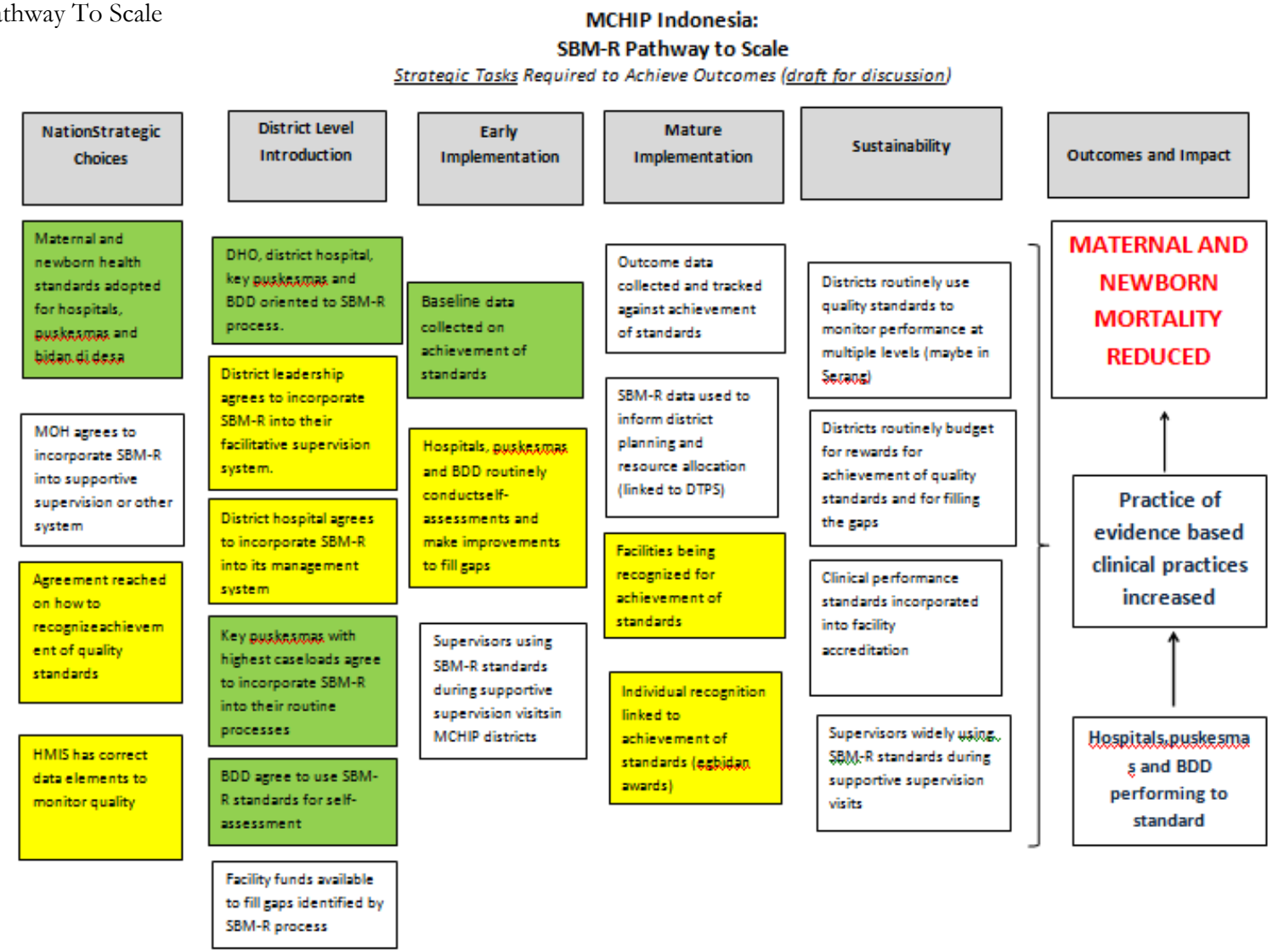
No	Training	Bireun			Kutai Timur			Serang			All Districts		
		Total	M	F	Total	M	F	Total	M	F	Total	M	F
3.4	IP Training	145	26	119	112	33	79	138	24	114	395	83	312
3.5	KMC Training	33	5	28	26	3	23	34	2	32	93	10	83
3.6	Lactation Management Training	30	2	28	24	1	23	30	3	27	84	6	78
3.7	Learning Organization Training	24	3	21	15	4	11	22	3	19	61	10	51
3.8	PONED Training	0	0	0	7	1	6	4	0	4	11	1	10
3.9	PONEK Training	0	0	0	0	0	0	2	1	1	2	1	1
3.10	Training Evaluator for the Effect of Intervention Quality on MNCH Service	9	1	8	0	0	0	0	0	0	9	1	8
3.11	OJM for health provider	0	0	0	0	0	0	131	1	130	131	1	130
3.12	MNERC Training	0	0	0	0	0	0	10	3	7	10	3	7
3.13	TOT MPA	0	0	0	0	0	0	5	3	2	5	3	2
3.14	MPA Training	0	0	0	0	0	0	119	1	118	119	1	118
	TOTAL	**343**	**37**	**306**	**185**	**42**	**143**	**545**	**49**	**496**	**1073**	**128**	**945**
SO 4: Improved Management of the District Health System													
4.1	TOT Pramusrenbangdes	28	10	18	18	10	8	24	14	10	70	34	36
4.2	TOT DTPS	36	5	31	0	0	0	0	0	0	36	5	31
4.3	PTP Workshop	64	23	41	51	27	24	60	20	40	175	70	105
4.4	DTPS Workshop	26	12	14	12	6	6	26	10	16	64	28	36
4.5	PWS-KIA Orientation	0	0	0	178	40	138	0	0	0	178	40	138
4.6	PWS-KIA Training	0	0	0	111	1	110	40	2	38	151	3	148
4.7	Advocacy Training DTPS-KIBBLA	13	4	9	0	0	0	0	0	0	13	4	9
	TOTAL	**167**	**54**	**113**	**370**	**84**	**286**	**150**	**46**	**104**	**687**	**184**	**503**
	TOTAL	**1,176**	**98**	**1,078**	**1,347**	**324**	**1,010**	**1,308**	**135**	**1,173**	**3,831**	**557**	**3,261**

Annex 3

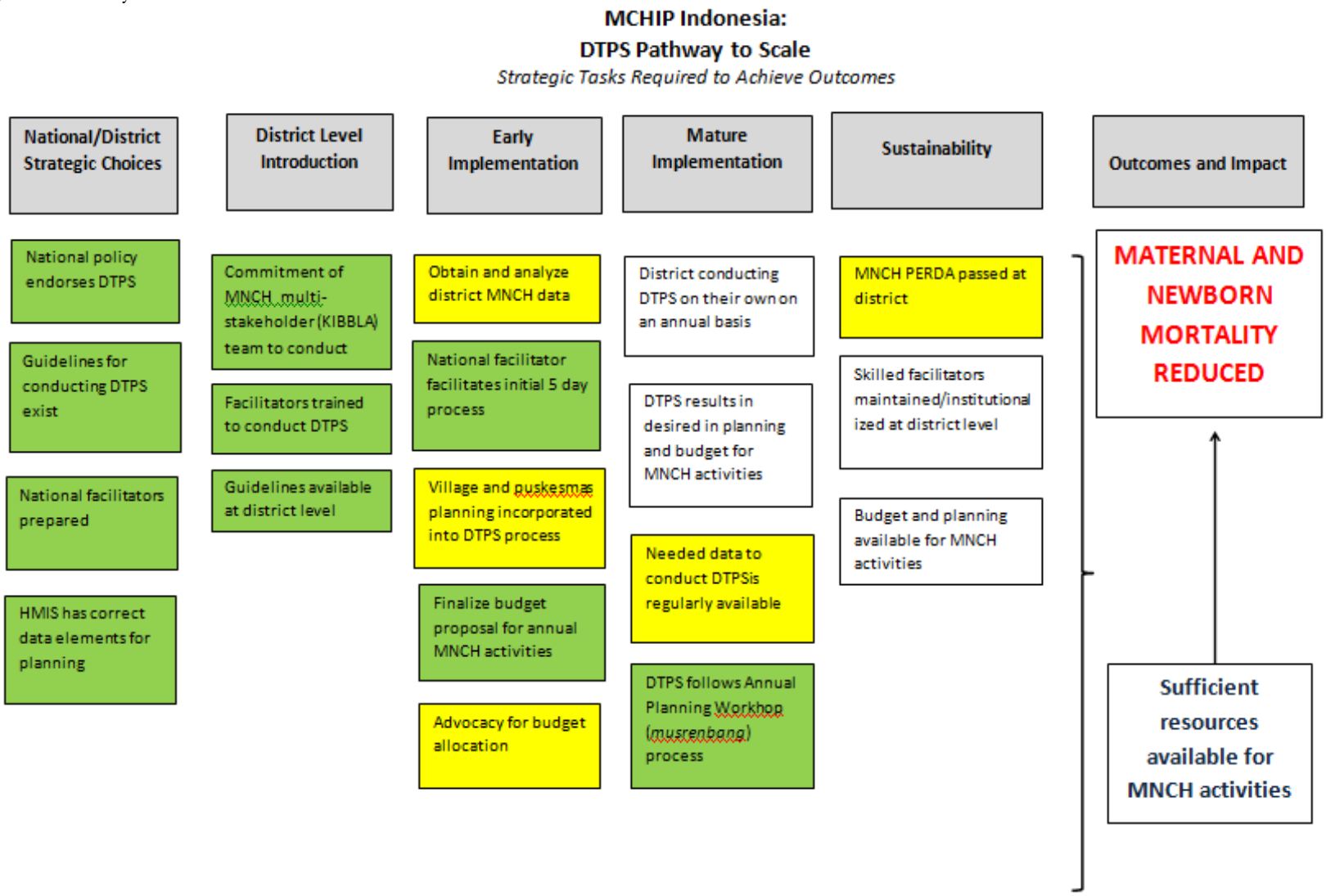
The Global Program Learning Framework



Annex 4
SBMR Program Pathway To Scale

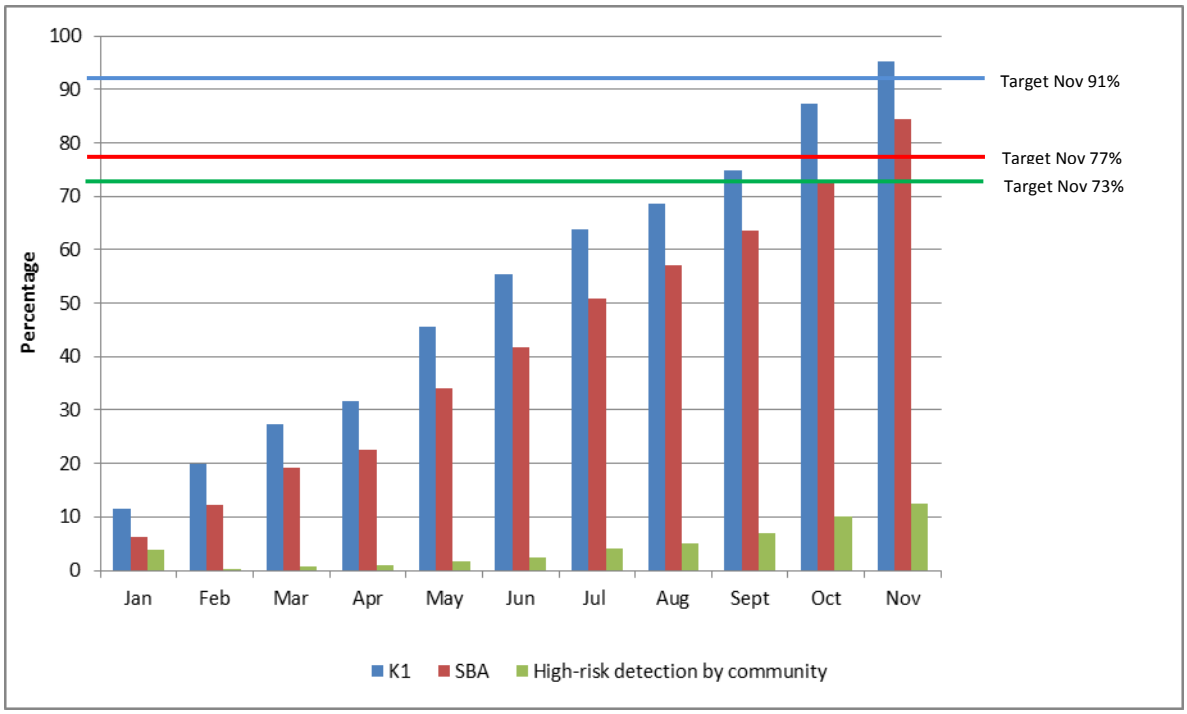


Annex 5
DTPS Program Pathway To Scale

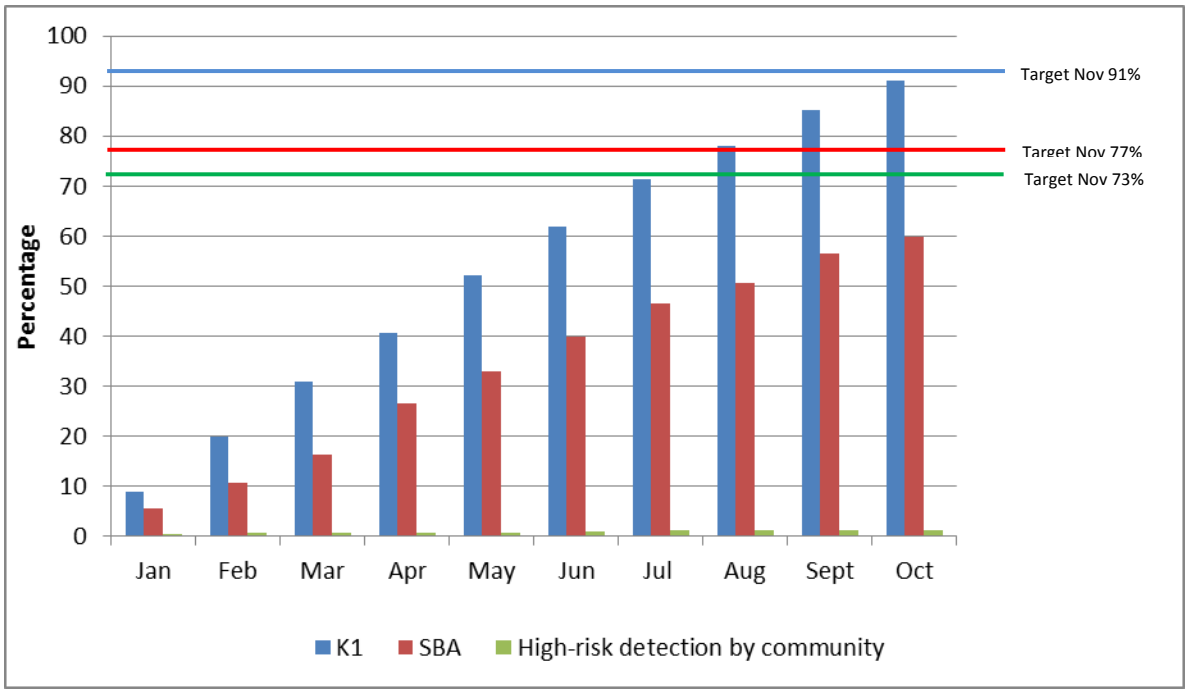


Annex 6
Coverage of Antenatal (K1), skilled birth attendant and high-risk detection by community in Bireuen and Kutai Timur district in 2011

6.1 Bireuen District



6.2 Kutai Timur



Annex 7
Newspaper Article on MCHIP Program Activities

7.1 Midwife-TBA Partnership Program in Kutai Timur (*Kaltim Post*, 19 October 2011)

SELAMATKAN ANAK-IBU: Suasana sosialisasi program kemitraan bidan dan dukun desa.

Dukun Desa Kerja Sama Bidan

Untuk Kurangi Kematian Ibu dan Anak saat Persalinan

SANGATTA- Salah satu faktor yang menyebabkan tersalinya kematian ibu maupun bayi adalah keterbatasan jumlah dan keterampilan tenaga kesehatan sebagai penolong pertama pada persalinan tersebut.

Di samping itu, masih tingginya persalinan di rumah dan masalah yang terkait budaya dan perilaku serta tanda-tanda sakit pada neonatal yang sulit dikenali, juga merupakan penyebab kematian bayi baru lahir.

Menurut Jambur Rosih dari MCHIP (*Maternal and Child Health Integrated Program*) Kutim, sesuai hasil penelitian dari 97 negara, ada korelasi yang signifikan antara pertolongan persalinan dengan kematian ibu. Semakin tinggi cakupan persalinan oleh tenaga kesehatan di suatu wilayah akan diikuti penurunan kematian ibu di wilayah tersebut.

Namun sampai saat ini di wilayah Indonesia masih banyak pertolongan persalinan dilakukan oleh dukun yang masih menggunakan cara-cara tradisional. Ini bisa merugikan dan membahayakan kesehatan ibu dan bayi baru lahir.

Kematian di beberapa daerah, kebercadaan dukun sebagai orang kepercayaan dalam menolong persalinan, merupakan sosok yang dihormati dan berpengalaman serta ketersediannya masih sangat dibutuhkan oleh masyarakat. Berbeda dengan ketersediaan bidan, yang rata-rata masih muda dan belum seluruhnya mendapatkan kepercayaan dari masyarakat.

"Sebagian pasien dari suatu kegiatan yang dapat membuat kerjasama saling menguntungkan antara bidan dengan dukun, dengan harapan pertolongan persalinan akan berpindah dari dukun ke bidan," kata Jambur.

Dengan demikian, kematian ibu dan bayi diharapkan dapat diturunkan dengan mengurangi risiko yang mungkin terjadi bila persalinan tidak ditolong oleh tenaga kesehatan yang kompeten dengan menggunakan jalur kemitraan bidan dengan dukun.

Salah satu langkah kerjasama yang dilangsungkan untuk mengatasi masalah tersebut, antara lain, dengan membuat program antara bidan bersalin dan dukun beranak agar ananinya para bidan dan dukun desa dapat memahami tugas pokok dan fungsinya masing-masing.

Pemerintah Kabupaten Kutai Timur melalui Dinas Kesehatan bekerjasama dengan MCHIP, belum lama ini, telah memasilitasi sosialisasi sekaligus penandatanganan program kemitraan antara bidan dan dukun untuk dua kecamatan yakni Rantau Pulung dan Teluk Pandan.

Untuk penandatanganan progrim kemitraan di Rantau Pulung dilaksanakan pada 15 Oktober lalu dan Teluk Pandan 18 Oktober.

"Karena sesuai aturan saat ini, dukun tidak boleh langsung menangani persalinan melainkan membantu merujuk kepada bidan terlatih untuk membantu proses persalinan," sebut Jambur.

Acara penandatanganan program kemitraan ini disaksikan perwakilan dari Dinas Kesehatan, camat dan aparat desa, pimpinan Puskesmas & Bidan Koordinator, Kader Pengerak SIAGA KIBBLA, tenaga kesehatan yang bertugas di Puskesmas Pembantu, serta penolong persalinan tradisional, yakni dukun.

"Penandatanganan disaksikan semua pihak agar hasil kesepakatan kemitraan bidan dengan dukun dapat dikawal oleh seluruh masyarakat di semua desa," katanya.

Selain itu kesepakatan tersebut diharapkan mendapatkan dukungan dari pemangku kepentingan di setiap desa mengenai penerapan kemitraan bidan & dukun.

"Pemangku kepentingan dan masyarakat diharapkan dapat ikut memantau dan mengevaluasi proses penerapan kemitraan bidan & dukun di desa," jelasnya. (kmf4/ha)

7.2 Handwashing With Soap (HWWS) Program in Kutai Timur (*Kaltim Post*, October 2011)

Kaltim Post, October 18, 2011

AGENDA

PANITIA KABUPATEN: Panitia Pekan Imunisasi Nasional (PIN) melaksanakan rapat pemantapan di Kantor Dinas Kesehatan.

Hari Ini, Pekan Imunisasi di Puskesmas Teluk Lingga

DINAS Kesehatan Kutai Timur bekerja sama dengan United States Agency International Development (USAID) mengadakan kegiatan Pekan Imunisasi Nasional (PIN) dan penimbangan balita yang dipusatkan di Puskesmas Teluk Lingga, Sangatta Utara, Selasa (18/10) ini. Acara tersebut, sekaligus dirangkai dengan aksi Cuci Tangan Pakai Sabun (CTPS).

Penjelasan itu disampaikan ketua panitia Husaini ketika ditemui di kantornya, Senin (17/10) kemarin. Tujuan pekan imunisasi, penimbangan balita dan CTPS menurutnya, adalah untuk meningkatkan derajat kesehatan kaum ibu dan anak, serta terjaminnya gizi balita. (km12/san)

Kaltim Post, October 18, 2011

Warga 48 Desa Diajak Cuci Tangan

SANGATTA- Pemerintah Kabupaten Kutai Timur bekerja sama dengan Maternal and Child Health Integrated Program (MCHIP) menyelenggarakan kegiatan cuci tangan pakai sabun (CTPS) serentak di enam kecamatan dan 48 desa se-Kutai Timur, Sabtu (15/10) lalu.

Menurut Jambur Rosli dari MCHIP, kegiatan yang dilaksanakan dalam rangka memperingati hari CTPS sedunia yang diperingati setiap 15 Oktober tersebut dilakukan di enam Puskesmas. Masing-masing Puskesmas Teluk Pandan, Puskesmas Rantau Pulung, Puskesmas Bengalon, Puskesmas Kaliorang. Berikut Puskesmas Kaubun, Puskesmas Sangkulirang.

"Tujuannya untuk meningkatkan pengetahuan masyarakat tentang pentingnya cuci tangan pakai sabun untuk mencegah bayi baru lahir terkena infeksi yang dapat menyebabkan kematian. Selanjutnya meningkatkan perilaku cuci tangan pakai sabun para penolong persalinan, seperti bidan dan dukun bayi serta menyiapkan lingkungan untuk mendukung program CTPS untuk Bayi Baru Lahir," kata Jambur.

Dijelaskan lebih jauh, kegiatan CTPS di 6 Puskesmas itu bertema "Cuci Tangan Pakai Sabun untuk Menyelamatkan Bayi Baru Lahir" pada 15 Oktober lalu, melibatkan Pimpinan Puskesmas dan Staf Puskesmas mempraktikkan 7 langkah cuci tangan pakai sabun yang benar. Kemudian mengajak semua pasien dan pengunjung yang datang ke Puskesmas melakukan cuci tangan, khususnya mereka yang mempunyai bayi. Setelah praktik CTPS yang didampingi tenaga kesehatan di Puskesmas, pasien mendapatkan suvenir berupa handuk dan sabun serta leaflet CTPS.

Selanjutnya Jambur menjelaskan alasan mengapa budaya CTPS itu penting, antara lain karena cuci tangan telah menunjukkan penurunan risiko infeksi pernafasan, pneumonia dan infeksi nosokomial pada balita.

Studi lain menyebutkan cuci tangan pakai sabun menunjukkan adanya penurunan angka kematian bayi baru lahir (BBL) jika ibu, keluarga, bidan dan dukun bayi mencuci tangannya dengan sabun sebelum proses kelahiran dan pada waktu sebelum merawat bayi.

Saat ini masih ditemukan program cuci tangan belum termasuk dalam ingatan bidan. Mengapa demikian, karena bidan lebih mengingat hal lainnya, seperti nutrisi, ASI dan kunjungan ulang pemeriksaan dalam konselingnya kepada ibu yang baru memiliki bayi baru lahir. (km14/san)

SERENTAK: Pengunjung Puskesmas Teluk Pandan diajak cuci tangan pada CTPS se-Dunia, 15 Oktober lalu.

Kaltim Post, October 19, 2011

Pekan Imunisasi di Teluk Lingga

BROSUR: Panitia membagikan brosur tentang cara tepat mencuci tangan dengan sabun.

Kaltim Post, October 23, 2011

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KUTAI TIMUR

Sukseskan Revitalisasi PERTANIAN

KUTIM CEMERLANG

"CTPS Jangan Hanya Seremonial"

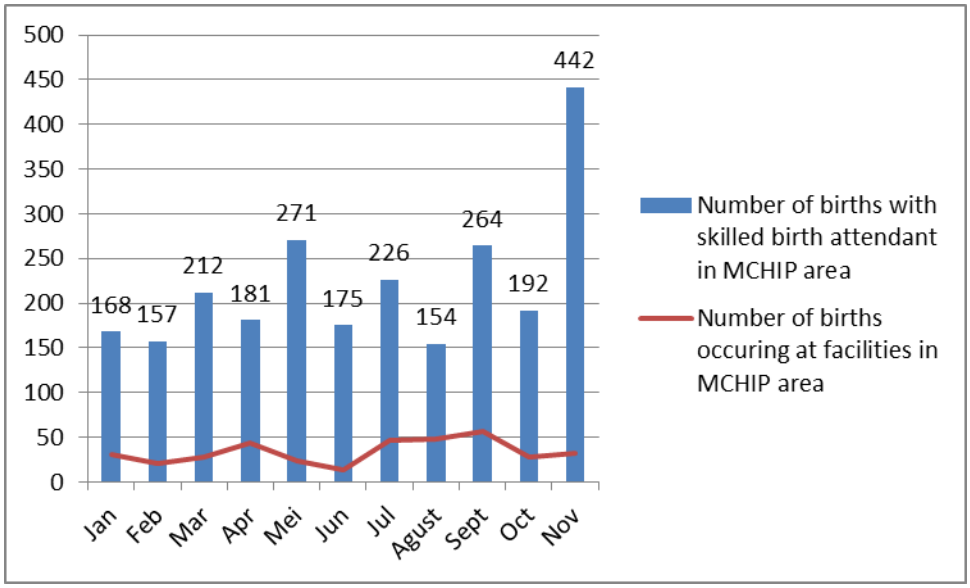
7.3 Local Law Advocacy Activities in Kutai Timur (*Kaltim Post*, October 2011)

DPRD KUTAI TIMUR

Pansus Perda KIBBLA Dibentuk

Annex 8
Number of Monthly SBA and Birth at Facility in Bireuen and SerangDistrict in January—November 2011

8.1 Number of Monthly SBA and Birth at Facility in Bireuen District in January—November 2011



8.2 Number of Monthly SBA and Birth at Facility in Serang District in January—November 2011